BlueCross BlueShield
Federal Employee Program

Shaded Area is for Plan Use Only

DENTAL CLAIM FORM

PLEASE TYPE OR PRINT

1. Identification Number	2. Group Number or Enrollment Code	3. Patient's Name *(First, Middle Initial, Last)*

4. Patient's Date of Birth Mo. / Day / Year	5. Patient's Sex	6. Patient's Relationship to Subscriber: EE SP CH
	Female ☐ Male ☐	*Self* ☐ *Spouse* ☐ *Child* ☐ *Other* ☐ *Explain:*

7. Subscriber's Name *(First, Middle Initial, Last)*	8. Daytime Telephone Number *(Include Area Code)*

Subscriber's Address *(Street and Apt. or Box Number)* ☐ *CHECK IF NEW ADDRESS*	*City*	*State*	*Zip Code*

Email Address

9. Is the patient covered under other dental insurance? No ☐ Yes ☐

If yes, name of other insurance: _____

Name of Policy Holder _____

Other Policy ID Number _____

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POI ☐

SOPL ☐

10. Was patient's condition due to:

Work related accident? No ☐ Yes ☐

An auto accident? No ☐ Yes ☐

Other accidental injury? No ☐ Yes ☐

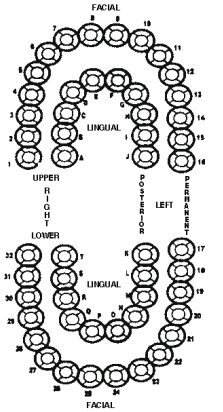
If yes, give the date of accident: Mo. / Day / Year _____

Please attach a statement with details indicating when, where and the manner in which the injury occured.

Was another party at fault? No ☐ Yes ☐

To be completed by Dentist (See instructions on reverse.)

Identify Missing Teeth With "X"



13. MISSING TEETH:

Identify missing teeth on chart with X. Indicate by tooth number, the date each tooth was lost or extracted, if known:

TOOTH	DATE	TOOTH	DATE

11. THIS CLAIM FORM MUST BE SIGNED. IF NOT, IT WILL BE RETURNED. I certify that the above information is correct and apply for benefits under my dental coverage. I authorize any dentist or physician in possession of information concerning the patient to furnish such information upon request.

_____ _____

Signature of Subscriber or Spouse *Date*

14. ORTHODONTIA:

Is orthodontic treatment included in the services listed below? No ☐ Yes ☐

If yes, is this initial treatment? No ☐ Yes ☐

Date appliance was placed: _____

Expected completion date of orthodontic treatment: _____

Total charge for active treatment _____

12. ASSIGNMENT OF BENEFITS: (Please see the reverse side of this form for further information.)

No ☐ Yes ☐

If "yes" block above is marked, I authorize the Blue Cross and Blue Shield Plan to pay benefits directly to the provider of the services listed below.

_____ _____

Signature of Subscriber or Spouse *Date*

The Plan may, at its discretion, accept or deny an assignment of benefits.

15. CROWNS, BRIDGES AND DENTURES:

Do services include the replacement of a prosthesis (crown, bridge, denture)? No ☐ Yes ☐

If yes, what was the orginal prosthesis? _____ Mo. / Day / Year _____ Tooth Number(s) _____

Indicate date of original placement or restoration and orignal teeth involved:

Reason for replacement: Original Damaged ☐ Lost or stolen ☐ Other: *(explain)* _____

See item 20 on the back of this form for x-ray requirements. _____

RPL ☐

SPI ☐

16. Do charges include a consultation? No ☐ Yes ☐ If yes, name of referring provider _____

A report from the consulting specialist is required. See item 16 on the back of this form for additional information required for a consultation.

17. **Description of Services** (See instructions on reverse.)

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Date of Service M	D	Y	A.D.A. Procedure Code	Detailed Description of Services	Tooth No. or Letter	Surfaces	No. of Times Perf.	Place OFF	Place IN	Place OP	Charge	Other Ins. Cons.	Other Ins. Paid	ADI	Remarks, Notes

19. TOTAL CHARGE

P = RC =

20. Are x-rays enclosed? No ☐ Yes ☐ (See item 20 on the back of this form.)

18. Please check the appropriate box.

☐ **ESTIMATE OF ELIGIBLE BENEFITS**

The treatment listed is necessary in my professional judgement and I request Estimate of Eligible Benefits . **Note: Dentist's Tax ID Number or Social Security Number is required.**

☐ **WORK COMPLETED - PAYMENT REQUESTED**

I certify that the services have been performed by me or under my personal supervision and are necessary in my professional judgement. Charges shown are my usual charges.

_____

Dentist's Signature *Phone #*

21.

_____

Dentist's Name

_____

Address

_____

City *State* *Zip Code*

☐ Tax ID No. or ☐ SSN

Reviewed By: _____

PAY ☐

DENTAL CLAIM FORM

GENERAL INFORMATION

Use this claim form to submit a claim for services which are covered under your dental program. To avoid delay in having your claim processed, please complete a separate claim form for each patient, and be sure that all information is complete and correct. Items 1 through 12 of this form must be completed by the subscriber or spouse, and items 13 through 21 are to be completed by the dentist.

When the claim form has been completed and signed, please mail it to your local Blue Cross and Blue Shield Plan.

INSTRUCTIONS FOR COMPLETING PATIENT AND SUBSCRIBER INFORMATION

Items 1-11: Complete all items as indicated on the front of the form.

Item 9: Please check yes or no in item 9. If yes, please provide information requested regarding your other dental insurance coverage. If payment has been received from another insurance company, please attach a copy of their Explanation of Benefits.

Item 12: **ASSIGNMENT OF BENEFITS** - Benefits for services provided by participating dentists are made payable directly to the dentist, whether or not benefits are assigned. Benefits for services provided by non-participating dentists located within our service area are made payable directly to the subscriber, regardless of any assignment of benefits. However, if the non-participating dentist is located outside our service area and you would like benefits due you for this claim sent directly to the dentist, complete item 12 on the reverse side of this form. Also, be sure the dentist's Tax ID Number or Social Security Number is included in item 21 with the dentist's name and address.

INSTRUCTIONS FOR COMPLETING DENTIST INFORMATION

Item 13: **MISSING TEETH** - Each claim for services involving missing or extracted teeth must include the information requested in item 13. To assist us in updating our records, with the submission of an initial oral exam, please include a complete charting of the patient's dentition.

Item 14: **ORTHODONTIA** - Claims for orthodontic services must include the information requested in item 14. It is not necessary for the orthodontic treatment to be completed before submitting the claim.

Item 15: **CROWNS, BRIDGES AND DENTURES** - Please complete this information on any claim for a crown, bridge or denture. See item 20 below for x-ray requirements.

Item 16: **CONSULTATIONS** - Claims for consultations must include a report from the consulting specialist indicating the name of the referring dentist or physician, the reason for the consultation, the treatment being considered and a description of the patient's oral condition.

Item 17: **ADA PROCEDURE CODES** - American Dental Association codes
TOOTH NO. OR LETTER - Refer to tooth chart on front of this claim form.
SURFACES - Use the following codes to identify tooth surfaces:
B = Buccal or facial D = Distal O = Occlusal
M = Mesial I = Incisal L = Lingual
PLACE - Please check the appropriate column on the claim form to indicate the place of service:
Off = Office IN = Inpatient Hospital OP = Outpatient Hospital
CHARGE - Indicate the individual charge for each service listed.

Item 18: **DENTIST'S CERTIFICATION AREA** - Please check the appropriate box to indicate whether the services listed have been completed. The dentist's signature and telephone number must also be completed in item 18.

ESTIMATE OF ELIGIBLE BENEFITS - If no dates of service are indicated on the claim, we will provide an estimate of the benefits available for the services listed. The estimates are based on the information we have at the time the claim is reviewed. Estimates will be subject to eligibility, deductibles, and Plan maximums. Therefore, they may be affected by other payments made between the time the estimate is given and the time that the services are rendered. Actual payments will be made in the order that the claims are received.

If you are requesting a Estimate of Eligible Benefits, mark the Estimate of Eligible Benefits box in item 18. In addition, the dentist's name, address, and Tax ID Number or Social Security Number must be clearly written in item 21 of this claim form.

Item 20: **X-RAYS** - Post-operative x-rays are required for the review of claims for root canals. These x-rays are also needed to review claims for posts and cores following the root canals. Pre-operative x-rays are required for review of claims for crowns, crown build-ups, bridges, partial dentures and apicoectomies. For periodontal procedures, we need the most recent pre-operative x-rays and complete periodontal charting of the teeth involved in the treatment. We may also occasionally request x-rays for certain other procedures. All x-rays will be returned to the dentist after the claim has been reviewed. To expedite the processing of your claim and to assist us in the return of the x-rays, please include the patient's name and identification number as well as the dentist's name and address on the x-ray envelope.

Item 21: Each claim must include the dentist's name, address and Tax ID Number or Social Security Number. Please also check the appropriate box in item 21 to indicate the type of identification number used.